Women's Care

Patient Registration Information

Please Complete all sections and provide us with a copy of your medical coverage card.

Patient Information

Name: _____
(Last) (First) (Initial) (Maiden Name)

Home Address: _____
(Streeet/Apt No.) (City) (State) (ZIP CODE)

Mailing Address: _____
(Streeet/Apt No.) (City) (State) (ZIP CODE)

Phone Number: (Home) ( ) _____ (Work) ( ) _____ (Cell) ( ) _____

Birthdate: _____ Age: _____ SS# _____ Marital Status: _____

May we Text to confirm your appointment? Yes No May we call with medical/billing inform Yes No

Your Employer: _____ Work Address: _____

Spouse/Other Name: _____ (Work) ( ) _____ (Cell) ( ) _____

Do you have a Living Will? Yes No

Name and Address of Person Not Living With You

Name: _____
(Last) (First) (Initial) (Maiden Name)

Home Address: _____
(Streeet/Apt No.) (City) (State) (ZIP CODE)

Phone Number: (Home) ( ) _____ (Work) ( ) _____ (Cell) ( ) _____

Insurance Policy Holder Information

Name: _____ Self / Spouse / Parent / Other

Birthdate: _____ Social Security Number (Required) _____

Employer: _____ Work Phone Number: ( ) _____

Work Address: _____

Insurance Carrier: _____ Policy # _____

Claims Mailing Address: _____ Group # _____

Secondary Insurance Information

Name: _____ Self / Spouse / Parent / Other

Birthdate: _____ Social Security Number (Required) _____

Employer: _____ Work Phone Number: ( ) _____

Work Address: _____

Insurance Carrier: _____ Policy # _____

Claims Mailing Address: _____ Group # _____

Assignment of Benefits - Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Women's Care, and any assisting physicians, for services rendered. I understand that copays are due at the time of service and thant I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this valid as the original.

Your Signature _____ Date: _____

Michael Magee, MD
Brendan Mitchell, MD
Angela Piquard, MD
Maureen King, MD
Julie Martin, MD
Sherebanu Gaslightwala, MD
Malorie Howe, DO
Kelly Jarczyk, ARNP
Julie Brown, ARNP

Santa Fe Medical Building
9301 W 74th St. Ste 325
Shawnee Mission , KS 66204

Southridge Medical Building
12541 Foster St., Ste 240
Overland Park, KS 66213

913.384.4990 FAX 913.384.1310

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer if such information is presented. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Women's Care, PA**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Women's Care, P.A. does not participate in fund-raising acivities, therefore, we will not use your name and address for fund raising efforts.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information

- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Women's Care, PA Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Security/Privacy Officer.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Security/Privacy Officer
Women's Care, PA
9301 W. 74th St., Suite 325
Shawnee Mission, KS 66204

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Security/Privacy Officer
Women's Care, PA
9301 W. 74th St., Suite 325
Shawnee Mission, KS 66204
(913) 384-4990, ext. 310

Effective Date
This Notice is effective on or after April 14, 2003

Women's Care Division of Mid America Physician's Services LLC

Consent to Disclose Protected Health Information

I, _____, give my permission to disclose my health information to the following people listed below. I have the right to change, update or revoke this information at any time. This consent is effective for one year from the date signed, however, for your protection you will be required to update this form anytime changes need to be made. You must sign, put your date of birth and the date this form is completed at the bottom of this page for us to use this document for any reason to contact you or those listed.

Name_____ Name_____

Relationship_____ Relationship_____

Phone_____ Phone_____

- I understand that the information disclosed as directed about by Women's Care may be re-disclosed to additional parties and is no longer protected for reasons beyond our control.
- You have the right to receive a copy of this consent if requested.
- Completion of this consent is not a condition for treatment.

Listed below are telephone numbers that can be used to contact me, or for us to provide messages. Messages may include test results, as well as appointment and payment information.

My telephone numbers Ok to leave message?

#1_____ Y N

#2_____ Y N

Email address_____

*Required for access to our patient portal.

Pharmacy Information

Pharmacy name_____

Address_____

Phone _____

Signature_____

Date of Birth_____ Date_____

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by **Women's Care, PA** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. I have reviewed and, if requested, received a copy of the **Women's Care, PA** Notice of Privacy Practices.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Women's Care, PA may or may not agree to restrict the use or disclosure of your protected health information.

If **Women's Care, PA** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Women's Care, PA reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to **Women's Care, PA** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Date of Birth

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Financial Policy

Mid America Physicians, Services, LLC
The healthcare providers and staff of Mid America Physician Services, LLC, (MAPS) strive to offer comprehensive, quality care to all of our patients. We feel that it is appropriate to inform our patients in advance of the policies, procedures, and authorizations required that may ultimately affect their care.

Obviously, not all the policies, procedures or authorizations may apply to you, however please read each one carefully.

Cash Accounts
All patients without proof of insurance are responsible, at the time of service, for all expenses incurred during their office visit. MAPS offers a 20% discount to patients without insurance, **if payment is made at the time of service.**

Maps accepts cash, checks, Master Card, Visa, and Discover.

Payments Due at the Time of Service
All insurance co-pays, deductibles, and coinsurance are due at the time of service. If patient does not have their co-pay at the time of check-in, a $10.00 billing fee may be assessed. All balances after insurance has paid are due within 30 days of insurance payment. If account has *been* sent to an outside collection agency, that patient will have responsibility to pay all fees, court costs and other charges incurred in forwarding the unpaid balance to the collection agency. The patient will not be allowed to schedule future appointments, or seek medical advice until the unpaid balance has been paid in full.

Gardasil, Lupron, Depo or Rhogam Injections, IUDs and Non-Covered Services
Patients must call their insurance carrier, prior to their visit, to determine whether they have coverage for Gardasil, Lupron, Depo or Rhogam injections, non-diagnostic ultrasounds, STD testing, treatment for infertility, etc. Services that are not covered may be due at the time of service.

Referrals, Pre-Certification and Pre-authorizations
Certain insurance plans may require a referral. It is the patient's responsibility to obtain a referral from her PCP and to provide the referral to our office before her scheduled appointment. While we often try to complete pre-certifications and/or pre-authorizations as a courtesy to our patients, please know it is ultimately the patient's responsibility to ensure these authorizations are completed. In the event a surgery, hospital admission, or non-routine care is planned at any facility, the patient must notify their insurance company immediately.

Laboratory Testing
The patient's care may include outside laboratory testing. The patient will receive a separate billing for these services. If the patient's insurance plan requires the use of a specific laboratory, the patient must inform the nurse or the lab tech prior to the test. The office will not be responsible for specimens sent to the wrong laboratory. In many cases **the patients will request these non-covered tests which may include but are not limited to STD screenings and HIV** testing. The laboratory will submit charges for these tests but the patient is ultimately responsible for the fees if denied by their insurance company. Screening tests are typically NOT covered Please check with your insurance.

Disability, Insurance or Employment Forms
Patients may leave these forms at our office for completion after the patient portion has been completed. The staff will complete the form within ten (10) working days. There is a fee for each form (to obtain current fee information please contact our disability desk). Payment in full is required before the forms are released.

Missed Appointments
There may be a charge for missed appointments that are not changed or cancelled within 24 hours prior to their scheduled appointment.

Returned Check Fees
A returned check fee of $35.00 and may be assessed for a returned check. Patient may *be* required to pay cash or use a credit card for any future payments.

Medical Records Releases
Medical Records will be released when a valid HIPAA compliant authorization or a court-ordered subpoena is received

(please allow 7-10 business days for processing). Appropriate fees for the copying and mailing of medical records will be charged Please contact the Medical Records department for further information.

Discharge of a Patient
The providers have the right to discharge any patient from the MAPS practices at any time for various reasons, including but not limited to, failure to abide by financial policies, noncompliance with recommended treatment plans, drug-seeking activity, and any verbal or physical abuse of healthcare providers and staff.

Insurance Policy
MAPS participates with many health insurance carriers. It is the patient's responsibility to choose a healthcare provider that participates with their insurance plan. If the patient chooses to have a healthcare provider treat them outside of their insurance network, they will be responsible for all charges denied or reduced by their insurance plan. A current insurance identification card is required at each visit. If a patient is unable to provide an identification card, they will be required to pay for their treatment AT THE TIME OF SERVICE. The patient is also responsible for informing MAPS if their insurance policy has changed. In the event that claims are denied for timely filing and a new insurance card was not provided by the patient, the patient will then be responsible for those charges. The patient is ultimately responsible for all charges incurred.

Obstetric Patients
Obstetric patients with no insurance coverage or maternity benefits will be required to set up a payment plan through the billing department. This payment plan arrangement must be finalized prior to the patient's initial OB visit.

Services Provided to a Minor
If the patient is a minor, the adult guardian accompanying the minor is responsible for the co-pay and/or any applicable payments incurred during the office visit.

Collections
In order for us to service your account or to collect any amounts you may owe, our organization's representatives and vendors, including our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. You also agree that you may be contacted by sending text messages or emails if information is provided to us.

FINANCIAL POLICY ACKNOWLEDGMENT

I have read and understand the MAPS Financial Policy above. I have read the above disclosure and agree that MAPS, its vendors, and its debt agency may contact me as describe above.

Your signature below indicates you have read and agree to the terms of this financial policy.

Relationship to Patient Self Date

_____ _____ _____

Printed Name *Date of Birth*

_____ _____

WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 1)

Name	Date of Visit
Date of birth Age	Physician/CNM
Social Security Number	

Reason for visit

Allergies (Drug and Food or Latex Allergies)

Drug or Substance		Reaction

Medications (Prescribed Medications, Herbs, Vitamins and Over the Counter)

Name	Dose(i.e. mg)	Times you take this medication (i.e. Twice a day)

Diagnostics	Date	Result	
Last Pap Smear		Normal/ Abnormal	Other: List test and result
Mammogram		Normal/ Abnormal	
Bone Density		Normal/ Abnormal	
Lipid Panel		Normal/ Abnormal	
Thyroid testing		Normal/ Abnormal	
Colonoscopy		Normal/ Abnormal	

Contraception Current _____ Past _____

GYN History Date of last menstrual cycle? _____ Age of first menses _____

Have you ever taken hormone replacement therapy? YES / NO What? _____ How long? _____

Do you have a history of abnormal Pap Smears? YES/ NO When _____

If Yes, was treatment necessary? YES/ NO Type of treatment Antibiotic Cream/ Cryosurgery (freezing)
Laser / Leep / Cone Biopsy /

Do you have a history of sexually transmitted diseases? YES/ NO

Type Chlamydia/ Genital warts/ Gonorrhea/ HPV (Human papilloma virus)/ PID (Pelvic inflammatory disease)
Syphilis/ Trichimonas/ Herpes / Other _____

Have you received the Gardasil (HPV) vaccine? YES/ NO How many doses? _____

Have you ever taken fertility medications? YES/ NO Type _____

Do you have a history of endometriosis? YES/ NO Treatment _____

(At Appointment)

Nursing Documentation RN/MA _____

Weight _____ Height _____ Blood Pressure _____ Nurse for Exam Yes/No

Patient Name _____
DOB _____

WOMEN'S CARE COMPREHENSIVE HISTORY (PAGE 2)

Pregnancies Including current	Full Term Deliveries	Premature	Elective Abortion	Miscarriage/ Spon Ab	Ectopic	Multiple Births	Living Children

Past Pregnancies

Date Month/Year	Weeks of Gestation	Length of Labor	Birth Weight	Sex Male/Female	Type of Delivery	Preterm Labor Yes/No	Complications

If you have had an ectopic pregnancy, did you require surgery? YES / NO
Did you have an Ovary or Fallopian tube removed? YES / NO If yes, which one? _____

WOMEN'S CARE COMPREHENSIVE HISTORY PAGE 3
WC 1008

Patient Name _____
DOB

Past Surgical History (Throughout your entire life)

Type of Surgery	Date	Comments

Personal and Family Medical History — Place a check mark in the box if applicable for yourself or family member

Disease/ Medical Condition	Yourself	Family member	PLEASE EXPLAIN OR GIVE DETAILS HERE
Blood Clot/DVT			
Anemia			
Asthma			
Autoimmune Disease			
Bruising/Bleeding Disorde			
Coronary Artery Disease			
Cardiovascular Disease			
Anxiety			
Recurrent Urinary Tract Infections			
Elevated Cholesterol			
Diabetes/Gestational Diabetes			
Endometriosis			
Fibroids			
Gallbladder Disease			
Herpes Simplex Virus			
Hypertenstion			
Infertility			
Blood transfusions			
Osteoporosis			
Ovarian Cyst			
Breast disease			
Breast Cancer			
Ovarian Cancer			
Cervical Cancer			
Uterine Cancer			
Colon Cancer			
Thyroid Disease			
Stroke			
Polycysitic Ovarian Syndrome			
HIV/AIDS			
Other, explain			

Social History

Occupation _____ Marital Status Single/ Married/ Divorced/Separated

RACE (Medically Required CIRCLE ONE) AfricanAmerican Asian American Indian Caucasian Hispanic Indian Jewish/Eastern European Middle Eastern Pakistani Other _____

Do you currently smoke? YES/ NO Amount? _____ Did you smoke in the past? YES/ NO

When did you quit? _____ Ever tried to quit? YES / NO

Passive smoke exposure at home or work? YES / NO

Do you drink alcohol? YES / NO Type of alcohol _____ How often _____

Do you feel you drink too much alcohol? YES / NO

Do you eat/drink caffeine? YES/NO Type _____ Frequency _____

In a medical emergency, would you accept blood products? YES / NO

Have you ever sought treatment for alcohol or drug use? YES / NO / N/A

Do you currently use recreation drugs? YES/ NO What substances do you use? _____

Have you used recreational drugs in the past? YES / NO

Have you ever been abused ? YES / NO

Are you being abused at this time? YES / NO Are you concerned about your safety? YES/ NO

What is your sexual preference? Heterosexual/ Bisexual/ Lesbian